

FAX completed form to  
Change Healthcare  
1-866-964-3472

Wyoming Medicaid – Pharmacy Services Program  
PRIOR AUTHORIZATION REQUEST FORM  
**Hepatitis C Treatment**

**PHONE:**  
(For questions or inquiries ONLY)  
1-877-207-1126

Provider must fill in all information below. It must be legible, correct and complete or the form will be returned.

Client ID #: \_\_\_\_\_

Client's Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

Prescriber's Full Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Pharmacy NPI: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

<u>Drug Name</u> (List one drug per form)	<u>Strength</u>	<u>Dosage Instructions</u>	<u>Days Supply</u>	<u>Quantity</u>	<u>Refills</u>
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- 1. Has the client had a drug screening performed within the last thirty days?**  Yes  No

If yes, please include screening results and date with the completed prior authorization form. **If the drug screen is positive for illicit drugs or does not match the client's drug profile, the prior authorization will be denied.**
- 2. Has the client had an HIV test performed within the last thirty days?**  Yes  No

If yes, please include test results and date with the completed prior authorization form.
- 3. Has the client had a Hepatitis B test performed within the last thirty days?**  Yes  No

If yes, please include the test results and date with the completed prior authorization form.
- 4. If Vosevi is requested, has the client had SVR-12 testing?**  Yes  No

If yes, please include results and date with the completed prior authorization form.
- 5. Has the client completed the PREP-C (Psychosocial Readiness Evaluation and Preparation for Hepatitis C Treatment) survey?**  Yes  No

If yes, please include results and date with the completed prior authorization form. The PREP-C survey can be obtained at <https://prepc.org>.
- 6. Have the client and the prescriber completed the Wyoming Medicaid Client Disclosure and Commitment to Take Hepatitis C Medications form?**  Yes  No

If yes, please include this form with the completed prior authorization form.

**\*\*\* If no is circled for questions 1-6 above, the prior authorization request will be deferred until the step(s) is/are completed and the required documentation has been submitted to CHC.**

7. Does the client have cirrhosis?  Yes  No

8. If yes, is the cirrhosis compensated or decompensated? \_\_\_\_\_

9. Client's Hepatitis C Genotype \_\_\_\_\_

10. Please list any other Hepatitis C medications that will be given concurrently with the requested medication above as well as anticipated length of treatment.

	<u>Medication</u>	<u>Anticipated Length of Use</u>
A.	_____	_____
B.	_____	_____

11. Is this client Hepatitis C treatment naïve?  Yes  No

If no, please list previous treatments below:

	<u>Medication</u>	<u>Dates of use</u>	<u>Reason for Discontinuing</u>
A.	_____	_____	_____
B.	_____	_____	_____

***\*\*All clients that are approved for treatment of Hepatitis C will be referred to the Pharmacy Care Management (PCM) program for case management. Wyoming Medicaid will only cover one course of treatment per client.***

**Prescriber Signature:** \_\_\_\_\_ **Date(s) of Submission:** \_\_\_\_\_

***\* Prescriber's original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.***



### Wyoming Medicaid Client Disclosure and Commitment to Take Hepatitis C Medications

Please initial each statement that you have read and discussed the “Disclosure and Commitment to Take Hepatitis C Medications” form with your healthcare provider.

\_\_\_ I understand that I will be taking very potent and expensive Hepatitis C medication(s). After discussion of the nature, alternatives, risks and benefits of these medications with my prescriber, I agree to take them as instructed. I understand that this combination of medication is to manage my Hepatitis C and has shown a high chance of a successful response in the treatment of Hepatitis C when taken appropriately.

\_\_\_ I understand that there are risks to not treating chronic Hepatitis C, including disease progression, developing cirrhosis, liver cancer and liver failure. I also understand there are risks and hazards related to the use of these medications. The risks and benefits have been reviewed and discussed with me by my prescriber.

\_\_\_ I will commit to the following processes to help make this treatment successful:

- Daily adherence to medication unless told by prescriber/pharmacy to stop medication
- Timely laboratory monitoring per prescriber’s request
- Medication counseling, education and training regarding administration and side effects
- Telephone follow-ups with prescriber, pharmacy, Medicaid and the Pharmacy Care Management program
- No missed follow-up appointments with prescriber during this treatment

\_\_\_ I understand that if I am not committed to this regimen that I put myself in jeopardy with treatment failure and denial of medication coverage for this particular regimen by Wyoming Medicaid. I understand that only one course of therapy is allowed in my Wyoming Medicaid lifetime.

\_\_\_ I have been given an opportunity to ask questions about my condition, alternative treatment options and risks of treatment, and I believe that I have sufficient information to understand the content of this disclosure and commitment to this treatment option.

\_\_\_ I understand no warranty of guarantee has been made to me as a result of using this drug of the possibility of curing my condition. I acknowledge that I have been given a copy of this completed commitment form. I willingly give commitment to the following regimen.

- Harvoni 90/400 mg by mouth once daily
- Epclusa 400/100 mg by mouth once daily
- Mavyret 100/40 mg three tablets by mouth once daily
- Other: \_\_\_\_\_

\*Please note:

Zepatier requires testing for NS5A polymorphism  
Harvoni & Olysio require documentation of cirrhosis

Projected start date if regimen is approved by insurance: \_\_\_\_\_ Duration: \_\_\_\_\_ weeks

Client Name: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Client Phone Number: \_\_\_\_\_

I, the undersigned prescriber, do hereby affirm that I have disclosed all of the above statements with full explanation to the client. I have specifically explained that Wyoming Medicaid will only cover one such treatment for the client, and non-compliance with the prescribed Hepatitis C regimen may put the client in jeopardy for denial of coverage in the future.

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Prescriber’s original signature required; copied, stamped, or e-signatures are not allowed. By signature, the prescriber confirms the criteria information above is accurate and verifiable in client records.**

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Please fax completed form with the prior authorization request to Change Healthcare: 866-964-3472. For any other questions, please call the Change Healthcare Help Desk at 877-209-1264.